REVIEW

Resuscitation of general paediatrics in the UK

I Wacogne, R Scott-Jupp, T Chambers

Arch Dis Child 2006;**91**:1030–1032. doi: 10.1136/adc.2006.105478

''The report of my death was an exaggeration'', said Mark Twain. For a dying specialty, general paediatrics has certainly been looking very healthy recently. It is timely to examine why our specialty was thought to be at such risk, and to explore why, although in many cases shocked and confused, it is well on the way to recovery. This article explores what is needed to keep it healthy to ensure that the general paediatrician is at the centre of the delivery of paediatrics in the UK.

If you ask people in paediatrics or even those in other branches of medicine, ''What is general paediatrics'', you hear a variety of answers, which range from ''Picks up the pieces between proper specialties'', to ''Whatever general practitioners [family, primary care doctors] can't cope with''. It is not hard to hear the barely concealed underlying thought: ''Whatever I find too boring to have my own clinics filled with''. Although all of these have a grain of truth—for the speaker at least—we prefer the following:

> General paediatrics is the diagnosis from symptoms, signs, and investigations, of undifferentiated referred infants, children and young people. The General Paediatrician then initiates treatment which can be delivered personally or by another person or team, according to the needs of the child.

This definition places the general paediatrician at the heart of rational, thoughtful care of the child. It says, ''Bring me your unwell child, and I'll see what I can do for you, and I'll do what I can for you.'' Treatment, it should be noted, is limited only by imagination; it may be as straightforward as a prescription, or as complex as a contribution to local or national health policy. This fits well with the definition set by the Royal College of Paediatrics and Child Health (RCPCH) of what a paediatrician is.[1]

These contradictory views of the outsider and the insider are odd. None of this confusion exists if you ask someone for a definition of a general practitioner or an organ-based specialist. Ask several people what a respiratory paediatrician is, and you will at least get definitions that point in the same direction.

See end of article for authors' affiliations

Correspondence to: I Wacogne, Department of General Paediatrics, Birmingham Children's Hospital NHS Trust, Steelhouse Lane, Birmingham B4 6NH, UK; ian.wacogne@bch.nhs.uk

Accepted 17 July 2006

A TRICKY ADOLESCENCE

Much of what defines us as an adult is what we choose to become as an adolescent. It is worth examining the influences on our development as a specialty to see why we—or more accurately, our colleagues—are so confused.

> … In the beginning was the paediatrician and the paediatrician was actually an adult physician with an interest. And this person found that children were actually much more interesting than adults and so specialised in paediatrics. And they were the first general paediatricians because there was nothing else to be. And they were amazing at it, with extraordinary clinical skills and breadth of knowledge. And with the development of the speciality of paediatrics came the realisation that there were further specialities, and those great forebears to whom we owe our profession were interested in nephrology and genetics and development all at the same time …

Now, as these giants of paediatrics grew older, they found that their expanding role was augmented by people whose attention was—to the benefit of their patients—highly focused on their area of interest. This was especially true in the tertiary centres, but has been seen to a lesser degree more recently in the larger district general units. The giants found themselves the heads of several departments and, when they retired, they were replaced by people with specialist knowledge and, very importantly, with no interest in general paediatrics and little understanding of it.

The development of organ-specific or disease-specific paediatricians has undoubtedly been in sick children's interests. However, it has resulted in a mindset which holds that general paediatrics is, somehow, the simple end of a thing, the less complicated thing, even the childish thing that we put behind us as we develop into adulthood. This is particularly so in care of the newborn: the achievements of modern neonatology are spectacular, but limited to a fraction of the annual 600 000 or so births in the UK. However, the doctors specialising in neonatology now dominate thinking in care of all newborn, much of which is delivered by general paediatricians and midwives.

This view is reinforced by the structure of training in the UK, which might be regarded as saying, ''Do the basics—general paediatrics in the first years of higher specialist training. Then work out what you really want to be and choose a proper speciality.'' Thus, general paediatrics is the basics—which it is—and anyone could do it—which is a view worth examining. The concept, implicit in the proposals for streamlined training—churning out lots of general paediatricians by shortening training, and then admitting some into specialist training is, at best,

misguided. This implies to paediatricians in training that general paediatrics is of lower status than the specialties. At the same time, the British Paediatric Association, and then the RCPCH generated multiple specialty subgroups, with general paediatrics nearly the last to be formed, almost as an afterthought. This mirrors the comparatively poor development of academic general paediatrics.

The specialist general paediatrician needs to have a breadth of experience and knowledge which makes organ-specialty experience seem blinkered by comparison. The general paediatrician needs, as much as any specialist, to achieve the ideals discussed in the RCPCH document.[1]

WHY THE RE-EMERGENCE?

The general paediatrician never really went away, especially outside the tertiary centres. However, the role has been misunderstood, maligned and generally neglected in many places, for the reasons described above. Recently, however, several factors have led to the application of conductive pads to the chest of our unwell specialty, and electricity has been flowing. These factors include, in no particular order, and not limited to the following:

Past factors

- *Politics*. The closure of an inpatient unit can spell political suicide—witness Kidderminster.[2] One of the only seats lost by the Labour Government in the 2001 general election was to an independent candidate standing on a ''keep our local hospital open'' platform. If these sorts of units are to remain open they need to be supported by people with the skills described in our definition of a general paediatrician.
- *Time*. The European Working Time Directive and other factors have led to a well-publicised resident on call for some consultant general paediatricians in smaller units. This expensive solution can work only if this resident consultant provides, for most patients, definitive care. (See again the RCPCH definition of a paediatrician.)

The National Service Framework expects the following from our services:

- *Experience*. With the shortening of training, patient care depends on people who have a breadth of experience rather than depth. Often the most senior doctor resident in a hospital may have <2 years experience in paediatrics. That resident doctor needs the support of someone who knows a lot about a lot of things. (See again the RCPCH definition.)
- *Convenience*. When it comes to their child's health, most parents will put themselves to enormous financial and social inconvenience, and not even regard it as such. It behoves us to ensure that all intervention should be based on providing the best possible outcome with the least possible disruption. Services of general paediatricians can be configured towards this; providing a one-stop shop for most children most of the time, and close to where they live too. This brings us to:
- *Right place, right time*. Specialist units are often geographically too far from children's homes for them to be of everyday use. General paediatricians can provide the care the child needs, and where the child needs it. Some units, such as Crawley in Sussex, UK, no longer need in-patient beds because of close adjacent facilities. Others, such as at Weston-super-Mare, Somerset, UK, have never had them, but are developing imaginative and flexible acute general paediatric services tailored for, and responsive to, the needs of the local population and its family doctors. However, this requires that doctors, nurses and other health professionals are spread across the population to allow parents and children ready access to care.

Future drivers

Other future drivers include the following:

- *Cost*. The enormous pricing exercise under way in the National Health Service—Payment by Results—applies a fixed income to a hospital visit. The general paediatrician may provide a way to filter patients in the most appropriate way to the most expensive parts of our services—specialist reviews and investigation. (See the RCPCH definition again.)
- *Primary care*. General practitioners—family doctors—were at one point thought likely to undertake much of general paediatrics. This has not happened. The model from continental Europe, or even the US, of the office paediatrician acting as a primary care physician solely for children has not developed, and it may be a modification of this model that emerges: the general paediatrician with an interest in primary care.
- *The need for skills, rather than labels or silos*. Children with complex disease undoubtedly have complex healthcare needs that are best served by specialist clinicians. However, these healthcare needs do not confine themselves to a single-organ specialty group. It might even be argued that the more tertiary care specialists are associated with the care of a child, the more the child needs a general paediatrician to provide an overarching coordination of that care. Food allergy is a good example of this, recently reviewed by Niggemann and Heine.[3] This is especially important for the adolescent or the young adult transitioning between age-related services. Additionally, specialists may tend to overinvestigate.[4] (See, yet again, the RCPCH definition of a paediatrician.) These arguments extend to community paediatrics also; there has been a shift in the role of community paediatrics with a prickly tension between ''generalists'' and ''community paediatricians''.[5] If we focus on skills rather than labels, we provide what children need.
- *Appropriateness of care*. It would be a caricature to regard the future of acute general paediatrics as a matter for emergency physicians and intensive care physicians. Much of what comes unselected to emergency departments would be better dealt with by primary care physicians: while acknowledging the benefits to the critically ill child of the advanced paediatric life support culture, most sick children are not in extremis and need the skills of the generalist doctor and nurse.

COMING OF AGE AND COMING BACK TO LIFE

We have argued for a better understanding of what it is to be a general paediatrician, for its recognition as a proper specialty in itself—by colleagues, in the structure of training, in academic paediatrics and for the role of the general paediatrician at the centre of the delivery of paediatrics in the UK. Our problems are not unique to the UK, but we do perhaps have the mechanisms in place to ensure that here we can campaign on behalf of children. The RCPCH—with a majority of generalist members and fellows, but with a strongly specialist executive body—needs to recognise a specialist interest in being a generalist and cater for the breadth of generalists continuing education. As tertiary centres have recently noticed, and acted upon by merging with secondary care and general paediatric services, or by establishing brand new departments of general paediatrics, if general paediatricians did not exist it would be necessary to invent them.

ACKNOWLEDGEMENTS

Thanks to our local teams and the reviewers of this paper (Drs Andrew Boon and Deb Lee) for their expertise and advice in helping us to figure out who we are.

Authors' affiliations

I Wacogne, Department of General Paediatrics, Birmingham Children's Hospital NHS Trust, Birmingham, UK
R Scott-Jupp, Salisbury District Hospital, Salisbury, UK
T Chambers, Bristol Royal Hospital for Children, Bristol, UK

Competing interests: None declared.

REFERENCES

1 **Royal College of Paediatrics and Child Health**. *A framework of competences for core higher specialist training*. London: RCPCH, 2005.
2 **Gulland A**. Doctor wins seat in fight to save hospital. *BMJ* 2001;**322**:1443.
3 **Niggemann B**, Heine RG. Who should manage infants and young children with food induced symptoms? *Arch Dis Child* 2006;**91**:379–82.
4 **Benbassat J**, Gergawi M, Offringa M, *et al*. Variability in management of symptomless microhaematuria in schoolchildren. *Postgrad Med J* 1998;**74**:161–4.
5 **Ni Bhrolchain CM**. If community paediatricians did not exist, it would be necessary to invent them. *Arch Dis Child* 2005;**90**:986.

IMAGES IN PAEDIATRICS

doi: 10.1136/adc.2005.091793

Magnetic resonance imaging in suspected septic arthritis can avoid unnecessary surgery

Hip pain in children is a common presentation. Infective causes of pain and limitation of movement are usually due to septic arthritis or osteomyelitis.

A 6-year-old child presented to our orthopaedic department with pain in the right hip. He had a fall 4 days previously and sustained grazes to the right knee and shin. Although able to bear weight initially, he experienced increasing pain in his hip, and his mother noticed a limp and general malaise developing over the next 3 days.

The child was pyrexial (38°C) and all movements of the joint were guarded. Initial examination of the blood showed a raised white cell count and inflammatory markers. *x* Rays of the joint were unremarkable and emergency ultrasonography showed no collections or effusions in either the hip or the abdomen. Repeat blood cultures grew *Staphylococcus aureus* and intravenous antibiotics were started. An urgent bone scan was carried out to rule out osteomyelitis. Emergency magnetic resonance imaging was carried out and a diagnosis of pyomyositis in the gluteus medius was made.

The short tau inversion recovery coronal image shows increased signal intensity in the gluteus medius muscle (fig 1). The axial T2 slice shows mild volume increase in the gluteus medius and increased signal intensity throughout the gluteus medius (fig 2).

Untreated primary pyomyositis is a potentially serious condition if it is missed. A delay in diagnosis leads to abscess formation over a period of 3 days to 3 weeks,[1] which requires surgical intervention. Neglected cases could cause overwhelming sepsis, which might prove fatal.[2 3] If the condition is diagnosed early with magnetic resonance imaging, then it can be treated simply with intravenous antibiotics, yielding complete resolution of symptoms without surgical intervention.

D J Dowen, A L Khan, P D Henman
Orthopaedic Offices, Department of Trauma and Orthopaedics, Newcastle General Hospital, Newcastle upon Tyne, UK

Correspondence to: D J Dowen, Dunster House, The Avenue, Durham, DH1 4DX, UK; Daniel.dowen@nuth.nhs.uk

Competing interests: None.

Ethics approval: Written ethics approval has been obtained from the parents of the child.

Contributors: PDH developed the idea for this report. DJD wrote the report and conducted the literature review with help from ALK. All authors contributed to the final draft of the paper. DJD is the guarantor.

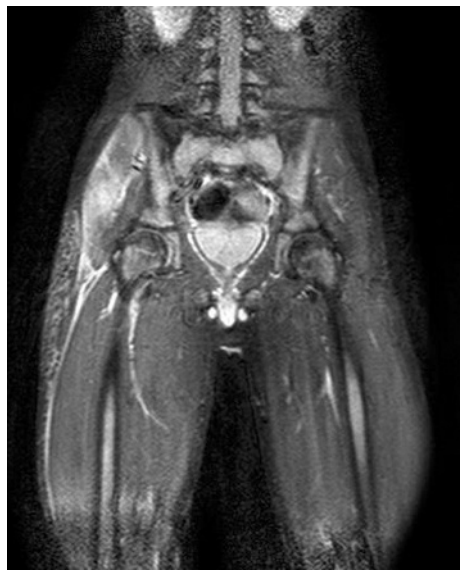

Figure 1 Short tau inversion recovery image showing increased signal intensity in the gluteus medius.

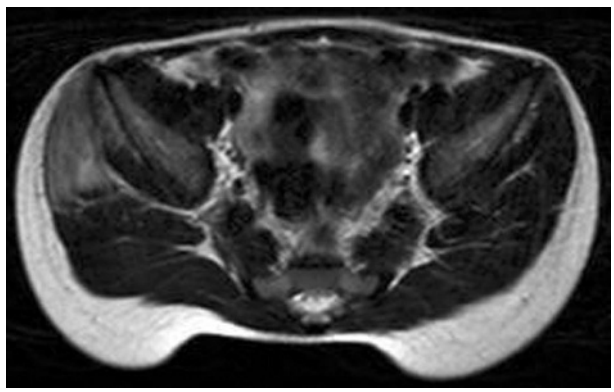

Figure 2 Axial T2 slice showing increased volume and signal intensity in the gluteus medius.

References

1 **King RJ**, Laugharne D, Kerslake RW, *et al*. Primary obturator pyomyositis: a diagnostic challenge. *J Bone Joint Surg Br* 2003;**85**:895–8.
2 **Renwick SE**, Ritterbusch JF. Pyomyositis in children. *J Pediatr Orthop* 1993;**13**:769–72.
3 **Bickels J**, Ben-Sira L, Kessler A, *et al*. Primary pyomyositis. *J Bone Joint Surg Am* 2002;**84-A**:2277–86.